



SELECT MY LOCATION

New Patient Intake Form

Please complete the intake form below to the best of your ability. This form covers many areas including your personal information, health history, eating and exercise habits, contact information for the individuals close to you, information about your health care providers and information about your insurance.

Before you begin, please make sure you have these materials accessible to you. Once you are ready to begin, please allow approximately 30-45 minutes of your time to complete the form as fully as you are able.

If you prefer, to print and **download the form** to complete and mail or upload below.

If you are filling out the Patient Intake Form on your phone, you can use the Adobe Fill & Sign app, which can be downloaded from your app store.

1. **Download the form** to your phone
2. Open the form in the Adobe app
3. Complete the form
4. Save it to your device

1. Select one of the highlighted links to open the Patient Intake form. Once the form is open you will be able to download it to your mobile device.

New Patient Intake Form (Bariatrics)

Please provide your demographic information below:

Patient Name _____
Preferred Name _____
Social Security Number _____ Age _____
Date of Birth _____ Sex _____
Preferred Phone _____ Alt Phone _____
Patient Address _____
City _____ State _____ ZIP Code _____
Email Address _____
Reason for No Email Address _____
Primary Care Provider _____

Primary Insurance _____ Secondary Insurance _____
Primary Member # _____ Secondary Member # _____
Primary Group # _____ Secondary Group # _____
Primary Policy Holder _____ Secondary Policy Holder _____
Policy Holder DOB _____ Policy Holder DOB _____
Relationship to Policy Holder _____ Relationship to Policy Holder _____
Guarantor Name _____ Relationship _____ Guarantor DOB _____
Emergency Contact _____ Relationship _____
Home Phone _____ Cell _____ Work _____
Patient's Race _____ Patient's Ethnicity _____
Preferred Language _____ Patient's Religion _____
How did you hear about our program?
 Referral from Doctor Referral from Friend Facebook Billboard Other _____

2. Click the share button in Safari's menu to open the Share Sheet.

New Patient Medical History (Bariatrics)

Patient Name _____ Date _____ Date of Birth _____
Please complete the questionnaire carefully and make your best guess when unsure of the answer. Please allow about 30 minutes to complete this questionnaire. Your answers will help us create your treatment plan. This information will become part of your medical record at MercyOne Northeast Iowa and may be shared with members of your treatment team. Thank you for taking the time to complete this questionnaire.
Referring Physician _____ Phone _____
Practice Name _____ Address _____
Primary Care Physician _____ Phone _____



12:37

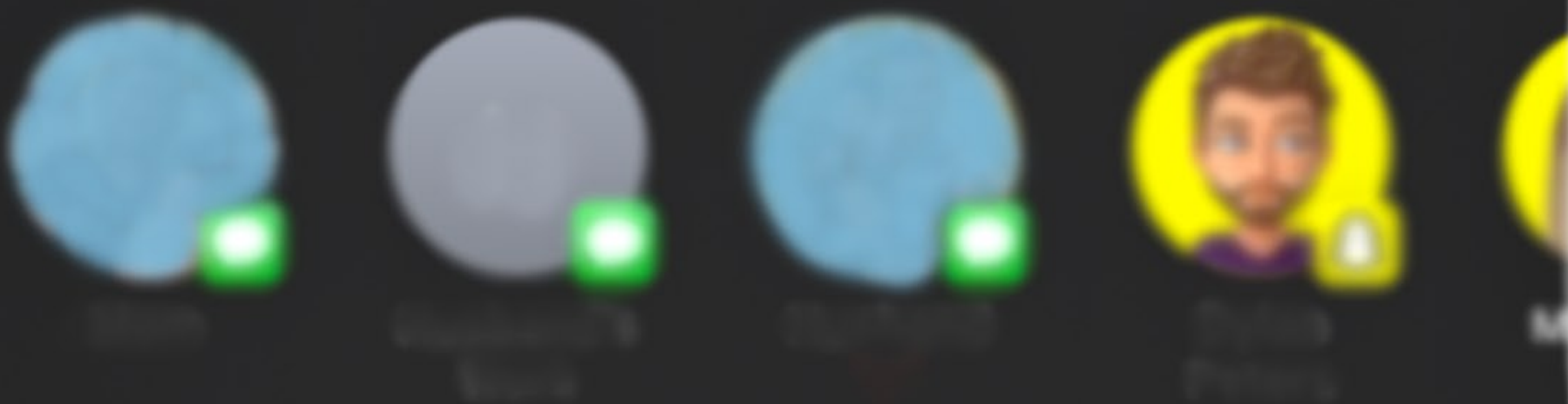


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PDF Document · 436 KB



Options >



AirDrop



Messages



Facebook



Instagram



Pi

Copy



Add to Reading List



Add Bookmark



Add to Favorites



Add to Quick Note



Find on Page



Add to Home Screen



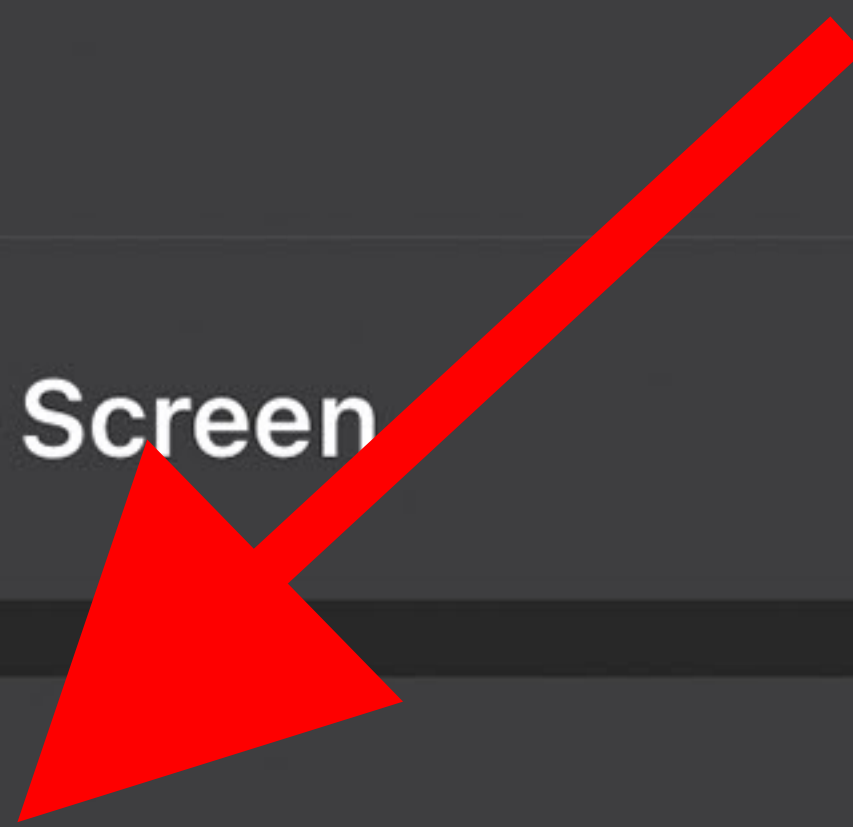
Save to Files



Markup



3. Click "Save to File." Select where you would like to save the file on your phone. This is personal preference.



< Search



Adobe Fill & Sign – Form Filler

Adobe Inc.

OPEN



107K RATINGS

4.8



AGE

17+

Years Old

CHART

#72

Business

DEVELOPER



Adobe

What's New

Version 23.2.0

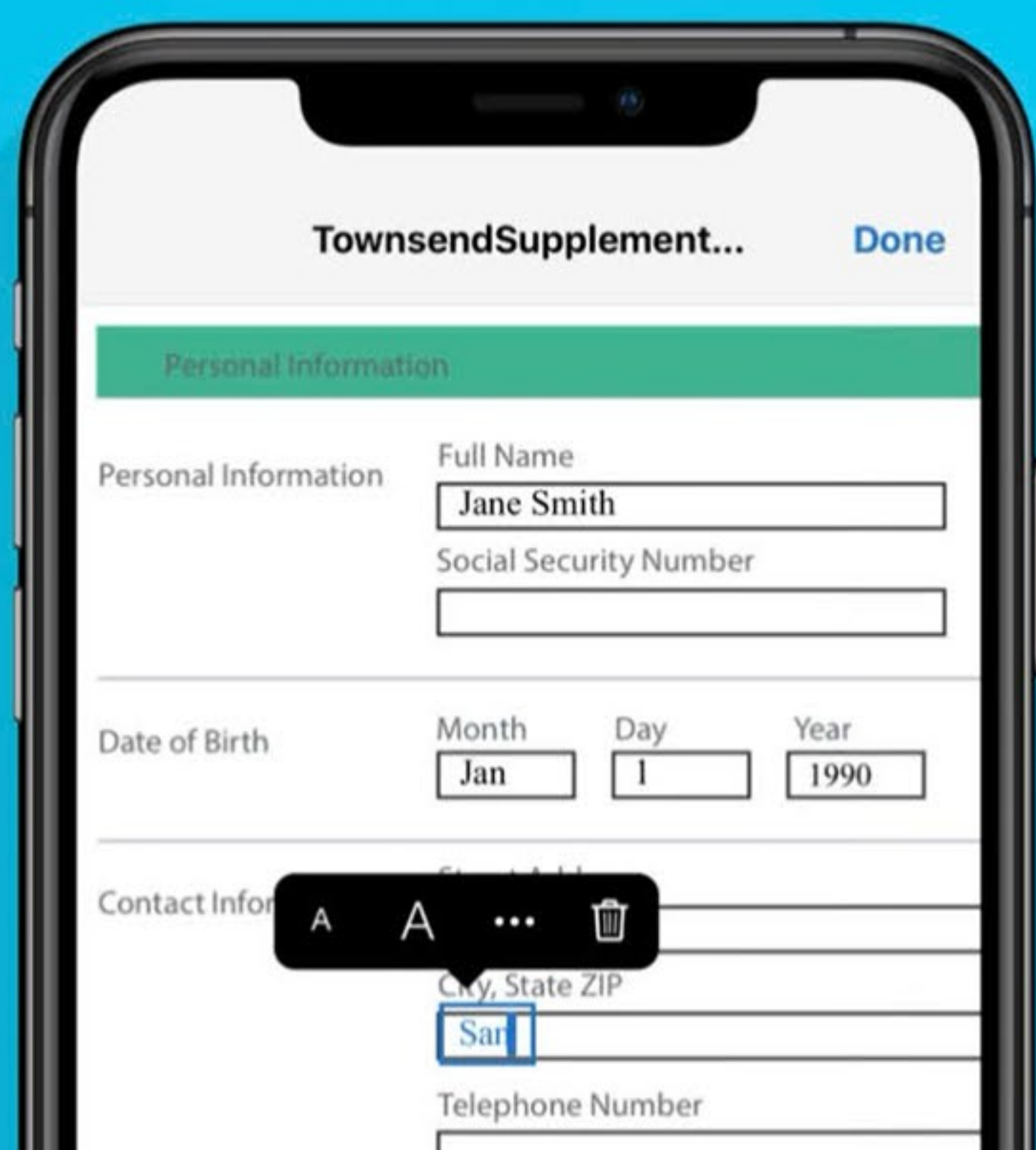
- Improved performance and stability
- Bug fixes

Version History

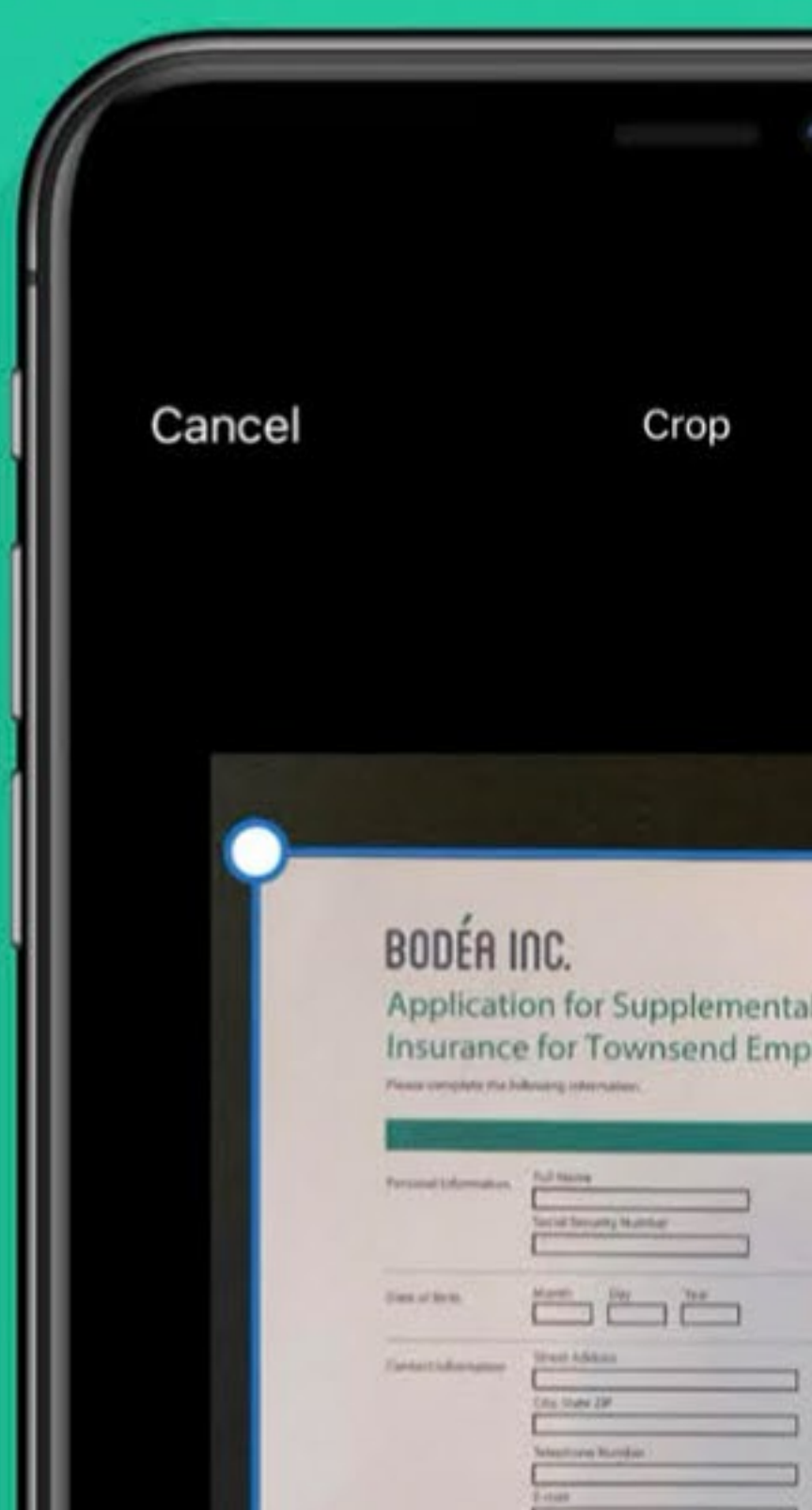
1mo ago

Preview

Fill any form.



Scan form with



Today



Games



Apps



Arcade



Search



Welcome to Adobe Fill & Sign

Sign in to sync your forms, signatures, and more across devices.



Sign in with Apple



Sign in with Facebook



Sign in with Google



Sign in with Adobe

Adobe collects analytics to improve your experience.
[Learn More](#)

5. Open the Adobe Fill & Sign application. Sign in.



Select a form to fill out

File Browser

Web URL

Web Search

Camera Roll

Take a Picture

Email Attachment

Cancel

5. Once you sign in, select “Select a form to fill out”. Then select “File Browser”. Find the form you saved earlier in your phone files. Select it to upload it to the Adobe Fill & Sign application.



Cedar Falls Weight Loss Center & Bariatric Surgery
515 College Street Suite 2800
Cedar Falls, IA 50613

New Patient Intake Form (Bariatrics)

Please provide your demographic information below:

Patient Name _____
Preferred Name _____
Social Security Number _____ Age _____
Date of Birth _____ Sex _____
Preferred Phone _____ Alt Phone _____
Patient Address _____
City _____ State _____ ZIP Code _____
Email Address _____
Reason for No Email Address _____
Primary Care Provider _____

Primary Insurance _____ Secondary Insurance _____
Primary Member # _____ Secondary Member # _____
Primary Group # _____ Secondary Group # _____
Primary Policy Holder _____ Secondary Policy Holder _____
Policy Holder DOB _____ Policy Holder DOB _____
Relationship to Policy Holder _____ Relationship to Policy Holder _____

Guarantor Name _____ Relationship _____ Guarantor DOB _____
Emergency Contact _____ Relationship _____
Home Phone _____ Cell _____ Work _____

Patient's Race _____ Patient's Ethnicity _____
Preferred Language _____ Patient's Religion _____

How did you hear about our program?
 Referral from Doctor Referral from Friend Facebook Billboard Other _____

6. Click anywhere on form to begin filling it out.





Cedar Falls Weight Loss Center & Bariatric Surgery
515 College Street Suite 2800
Cedar Falls, IA 50613

New Patient Intake Form (Bariatrics)

Please provide your demographic information below:

Patient Name _____
Preferred Name _____
Social Security Number _____ Age _____
Date of Birth _____ Sex _____
Preferred Phone _____ Alt Phone _____
Patient Address _____
City _____ State _____ ZIP Code _____
Email Address _____
Reason for No Email Address _____
Primary Care Provider _____

Primary Insurance _____ Secondary Insurance _____
Primary Member # _____ Secondary Member # _____
Primary Group # _____ Secondary Group # _____
Primary Policy Holder _____ Secondary Policy Holder _____
Policy Holder DOB _____ Policy Holder DOB _____
Relationship to Policy Holder _____ Relationship to Policy Holder _____

Guarantor Name _____ Relationship _____ Guarantor DOB _____
Emergency Contact _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Patient's Race _____ Patient's Ethnicity _____
Preferred Language _____ Patient's Religion _____

How did you hear about our program?
 Referral from Doctor Referral from Friend Facebook Billboard Other _____

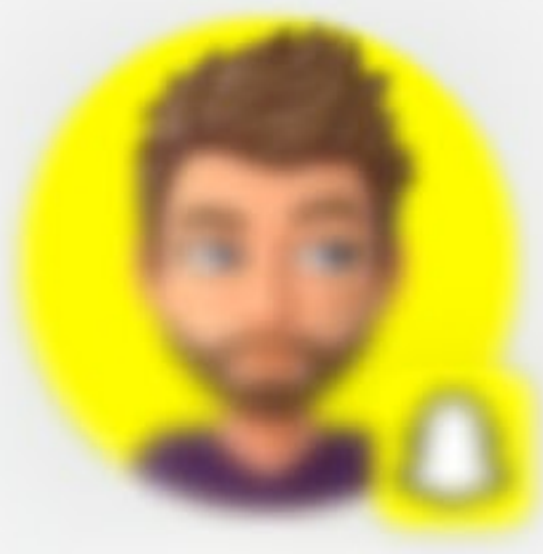
7. When the form is complete, select the share button again.





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PDF Document · 186 KB



AirDrop



Messages



Facebook



LinkedIn



Pi

Open In...



Export File...



Markup



Print



New Quick Note



Save to Files



Save to Pinterest



[Edit Actions...](#)

8. Click "Save to File." Save the completed form in the same location. It will override the existing.

12:39



MERCYONE



SELECT MY LOCATION

Upload your form here

First Name

MercyOne

Last Name

Iowa

Email

test@test.com

What Region/office are you closest to? *

Northeast Iowa (Waterloo-Cedar Falls)

Central Iowa (Des Moines)

Upload file

choose file from your computer or phone and load it here

Choose File

Remove File

No File Chosen

File uploads may not work on some mobile devices

AA

mercyone.org



9. Return back to Safari to the Patient Intake page on MercyOne's website. Scroll down till you see the form. Fill out the form. Click "Choose File" to upload your completed Patient Intake form.

SELECT MY LOCATION

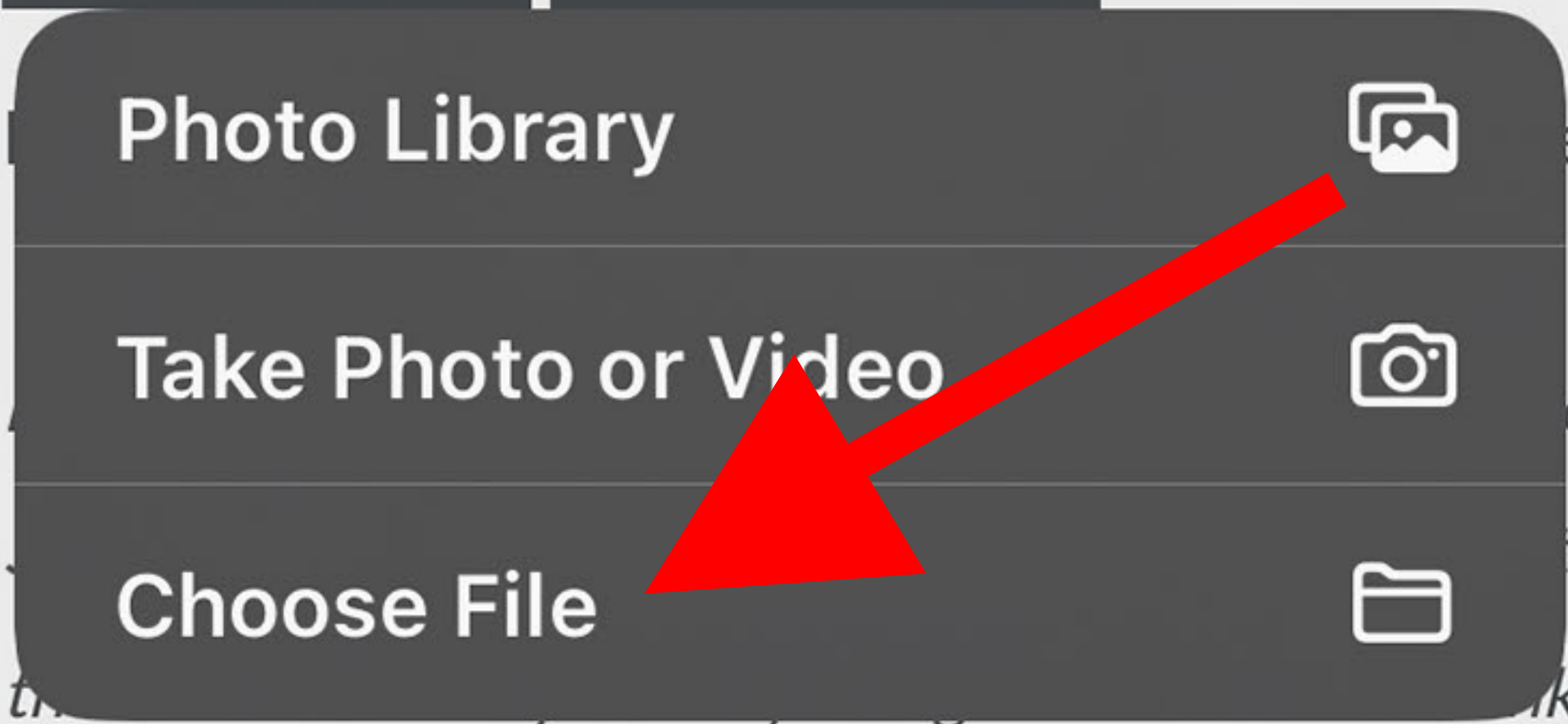
Northeast Iowa (Waterloo-Cedar Falls)

Central Iowa (Des Moines)

Upload file

choose file from your computer or phone and load it here

Choose File Remove File No File Chosen



bottom of every email. You can opt-out of texts/SMS messages at any time by responding STOP. You can also respond HELP for help. Msg & Data Rates May Apply.

Submit Form

10. Select "Choose File". Select your completed Patient Intake form to upload the file.

You can also mail form to: MercyOne Cedar Falls Weight Loss Center & Bariatric Surgery 515 College Street Suite 2800 Cedar Falls, Iowa 50613

FOR PATIENTS



SELECT MY LOCATION

Northwest Iowa (Waterloo, Cedar Falls)

Central Iowa (Des Moines)

Upload file

choose file from your computer or phone and load it here

Choose File

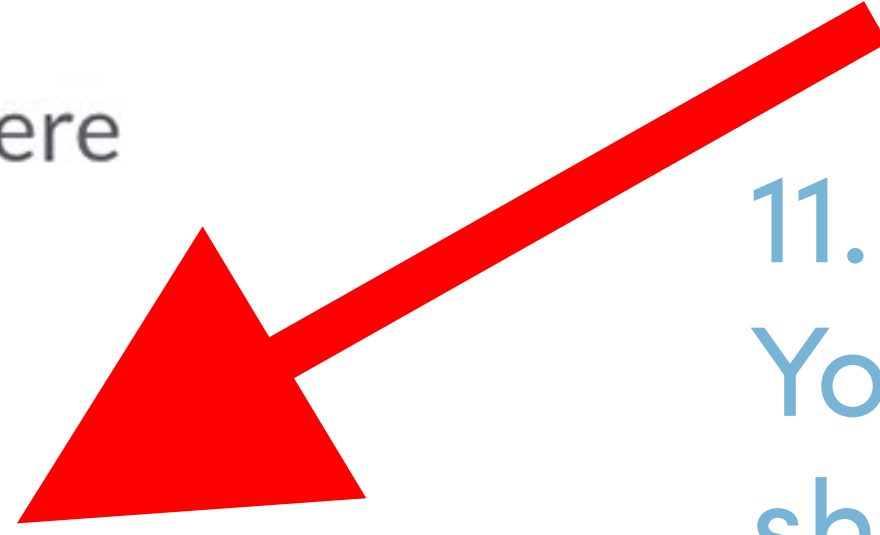
Remove File

spec_wght_nei_bariatric-new-patient-intake-form_092722_v1.pdf

File uploads may not work on some mobile devices.

By submitting this form, you are consenting to receive emails and SMS/text messages from MercyOne. You can opt-out of receiving these emails at any time by using the unsubscribe link, found at the bottom of every email. You can opt-out of texts/SMS messages at any time by responding STOP. You can also respond HELP for help. Msg & Data Rates May Apply.

Submit Form



11. Verify that the form is uploaded. You should see the file name shown in image to the left. Once you have verified the file is uploaded. Click the "Submit Form" button.

You can also mail form to: MercyOne Cedar Falls Weight Loss Center & Bariatric Surgery 515 College Street Suite 2800 Cedar Falls, Iowa 50613

